

# MARYLAND HEALTH CARE COMMISSION

## REPORTS REQUIRED UNDER SECTION 11 OF HOUSE BILL 995 (1999) – “Health Care Regulatory Reform – Commission Consolidation”

John M. Colmers  
Executive Director

Donald E. Wilson, M.D., MACP  
Chairman

Maryland Health Care Commission  
4201 Patterson Avenue, 5<sup>th</sup> Floor  
Baltimore MD 21215  
[www.mhcc.state.md.us](http://www.mhcc.state.md.us)

## **TABLE OF CONTENTS**

<b>Introduction</b>	<b>Page 3</b>
<b>Part I: Report on the Reorganization of the Health Resources Planning Commission and the Health Care Access and Cost Commission into the Maryland Health Care Commission</b>	<b>Page 4</b>
<b>Part II: Work Plan for Examining the Certificate of Need Process</b>	<b>Page 15</b>
<b>Part III: Work Plan for Examining Changes in Hospital Rate Regulation</b>	<b>Page 19</b>
<b>Part IV: Report on State Health Plan Transfer and Local Health Planning</b>	<b>Page 23</b>
<b>Part V: Work Plan for Examining Issues Related to the Comprehensive Standard Health Benefit Plan</b>	<b>Page 34</b>
<b>Part VI: Report on the Potential Merger of the Health Services Cost Review Commission and the Maryland Health Care Commission</b>	<b>Page 38</b>

## INTRODUCTION

During the 1999 session, the Maryland General Assembly passed House Bill 995, entitled *Health Care Regulatory Reform – Commission Consolidation (Chapter 702 Annotated Code of Maryland)*. The regulatory responsibilities and duties of the Maryland Health Care Access and Cost Commission and the Maryland Health Resources Planning Commission were integrated, consolidated, and streamlined under the Maryland Health Care Commission (MHCC).

Under Section 11 of House Bill 995, the Commission is charged with providing numerous reports to the General Assembly. This comprehensive report contains a number of those required reports including:

- **Part I:** a report on the reorganization of the Health Resources Planning Commission into the Maryland Health Care Commission as of the date of the report (HB 995: Section 11a);
- **Part II:** a report on the priorities, approximate time frames, and process for examining major policy issues related to the certificate of need process (HB 995: Section 11(d)(1)). A work plan has been developed to guide the future examination of this issue;
- **Part III:** a report on the priorities, approximate time frames, and process for examining major policy issues related to hospital rate regulation (HB 995: Section 11(d)(2)). A work plan has been developed outlining efforts currently underway by the Health Services Cost Review Commission;
- **Part IV:** a report on the priorities, approximate time frames, and process for examining major policy issues related to State and local health planning (HB 995: Section 11(d)(3)). The Commission has completed a report on State Health Plan Transfer and Local Health Planning;
- **Part V:** a report on the priorities, approximate time frames, and process for examining any other major policy issue (HB 995: Section 11(d)(4)). The Commission has provided a work plan to examine policy issues related to the Comprehensive Standard Health Benefit Plan that is utilized in the small group market; and
- **Part VI:** a report on the feasibility, desirability, and best method of reorganizing the duties and responsibilities of the Maryland Health Care Commission (MHCC) and the Health Services Cost Review Commission (HSCRC) under one commission. This section also includes an estimate of the time necessary to combine them (HB 995: Section 11(b) and 11(c)).

## **PART I**

### **Report on the Reorganization of the Health Resources Planning Commission and the Health Care Access and Cost Commission into the Maryland Health Care Commission**

Preliminary Report

## **Report on the Reorganization of the Health Resources Planning Commission and the Health Care Access and Cost Commission into the Maryland Health Care Commission**

During the 1999 session, the Maryland General Assembly passed House Bill 995, entitled *Health Care Regulatory Reform – Commission Consolidation (Chapter 702 Annotated Code of Maryland)*. The regulatory responsibilities and duties of the Maryland Health Care Access and Cost Commission and the Maryland Health Resources Planning Commission were integrated, consolidated, and streamlined under the Maryland Health Care Commission (MHCC). Uncodified language in Section 11 of the bill, as enacted, requires:

... on or before January 1, 2000, the Maryland Health Care Commission and the Health Services Cost Review Commission, in consultation with the Maryland Insurance Commissioner and the Secretary of Health and Mental Hygiene, shall review and provide a preliminary report, and on or before July 1, 2000, a final report, to the General Assembly on the reorganization of the Health Resources Planning Commission into the Maryland Health Care Commission as of the date of the report.

This report fulfills the requirement to provide a progress report on the consolidation activities that have occurred to fulfill the requirements of the law. It contains an organizational chart, a listing of MHCC Commissioners, and the merger activities that already have been undertaken. It also includes additional activities that will be undertaken in the future.

### **Reorganization of the Maryland Health Care Commission**

In order to accomplish a successful merger of the two commissions, numerous tasks had to be undertaken. An Executive Committee was formed to create a framework for those tasks and to provide guidance during the process. The Executive Committee was composed of the Executive Director of the former HCACC, the two deputy directors of the former HCACC and the acting Executive Director of the former HRPC who is now deputy director for Health Services. The Executive Committee was responsible for overall coordination, created the new organizational structure of the Commission, and also formed transition teams to address a number of issues related to the reorganization.

#### **Organizational Structure**

The new Commission has been organized into three main projects: Data Systems & Analysis; Health Resources; and Performance & Benefits (see Attachment - organizational chart). A deputy director who reports directly to the Executive Director heads each project. Under the direct authority of the Executive Director is the Executive Direction Division, which centralizes the key functions of budget, user fee assessment,

procurement, personnel, and legal services. The Chief of Administration and Operations manages the day-to-day operation of the budget, user fee assessment, procurement, and personnel functions and provides the Executive Director with ongoing status reporting of activities within each functional area. The Legal Services unit, composed of three Assistant Attorneys General, provides advice to the Executive Director.

**Data Systems and Analysis:** Data Systems and Analysis is composed of three divisions that are responsible for the analysis, collection, and management of information on health care cost and utilization. A fourth division promotes the adoption of electronic data interchange for administrative health care transactions between Maryland providers and payers.

- **Data Base and Application Development Division.** This division has three main functions: (1) Creation and maintenance of the data bases collected MHCC; (2) Administration of all aspects of survey operation including software design, help desk operation, and quality control; (3) Development of specialized software in support of MHCC research and internet efforts.
- **Cost and Quality Analysis Division** is responsible for the preparation of the state health care expenditure and physician utilization reports that are mandated by law. The division conducts specialized studies of specific conditions and examines broader health care issues, including use of health care services by specific populations and the issues affecting the uninsured.
- **EDI Programs and Payer Compliance Division:** This division develops programs to expand use of EDI in the state and manages insurance companies regulatory responsibilities on EDI and data reporting.
- **Network Operations and Administration Systems** maintains the internal computer networks, monitors utilization of resources, and enforces security measures. This division also provides support to MHCC staff on standard office software and financial systems.

**Health Resources:** The first three divisions develop components of the State Health Plan, which becomes a state regulation. The fourth section administers the certificate of need program, a regulatory program that is based on standards, criteria, and methodologies developed through the State Health Plan.

- **Acute and Ambulatory Care Services:** This division is responsible for development of State Health Plan sections covering the following services: acute inpatient services: medical–surgical, obstetrics, pediatrics; ambulatory surgical services, both hospital-based and freestanding. This division is also involved with downsizing the acute care hospital system and implementation of HB 994, the Hospital Capacity and Cost-Containment Act.
- **Specialized Health Care Services:** This division is responsible for development of State Health Plan sections covering the following services: cardiac surgery and

therapeutic catheterization, neonatal intensive care unit services, organ transplant services, and rehabilitation services, including: comprehensive inpatient rehabilitation, brain injury, spinal cord injury, and infant and early childhood injury. Due to the specialized clinical nature of these services, in the past, several technical advisory committees had been established by the former HRPC to advise staff in these areas. Reports have been developed by technical advisory committees on: rehabilitation, cardiac surgery and therapeutic catheterization, neonatal intensive care services, organ transplant services, and stem cell transplantation. Currently, a technical advisory committee on cardiovascular services is studying the impact of advances in diagnosing and treating heart disease on the future utilization and delivery of cardiac care services. Recommendations from the technical advisory committee will be submitted to the Commission at its December meeting.

- **Long Term Care and Mental Health Services:** This division is responsible for the development of State Health Plan sections covering the following services: Long Term Care Services, including: nursing home, subacute, home health, hospice, adult day care, continuing care retirement communities (CCRCs), and other community-based services; Psychiatric Services, including residential treatment centers and acute psychiatric services; and Alcoholism and Drug Abuse Treatment Services. Recently, this division developed a policy paper on CCRCs, updated hospice and home health need projections, participated in a work group on regional treatment centers, and convened a work group to assess the impact of changes to Medicare's method of paying home health agencies.
- **Certificate of Need Program:** Under the Commission's statutory authority, this division reviews applications that require approval under the certificate of need law. Regulated covered services include: acute general hospitals; special hospitals (chronic, psychiatric, rehabilitation, pediatric); comprehensive care facilities (nursing homes); extended care facilities; residential treatment centers; intermediate care alcoholism and drug abuse treatment centers; retardation (ICF-MR) centers; ambulatory surgical facilities; home health agencies; hospice; specialized services (open heart surgery, neonatal intensive care, organ transplants, and burn units).

**Performance and Benefits:** The three divisions reflect diverse projects, however, they are unified by the common theme of providing information to consumers and employers to make the health care marketplace more competitive in terms of lower cost and increased quality.

- **Benefits Analysis:** This division is responsible for two major projects, both related to the provision of health insurance. The first responsibility is to monitor the provision of coverage in the small employer market. The second area of responsibility is an annual evaluation of state mandated benefits which may impact the individual and large group markets.
- **HMO Quality & Performance:** This division is charged with collecting, and making available to the public, information to compare the performance and overall quality of commercial HMOs operating in Maryland. That information is intended to assist various groups of consumers, purchasers, and policy makers in assessing the relative

quality of services offered by commercial managed care plans. Such information is expected to affect purchasing and enrollment decisions and, through such impacts on the market, to improve the overall quality of care provided by commercial HMOs.

- **Legislative and Special Projects:** This division responds to special requests for information on health care delivery system issues that are made by the Maryland legislature, executive departments, and other external groups. The Division also serves as an incubator for newly mandated Commission activities, laying the groundwork for full implementation. Finally, the Division is also responsible for monitoring health care reform initiatives being undertaken in other states. The Division researches the current health care policies and benefits of those states to determine if their initiatives can improve access to, increase the quality of, or lower the costs of health care in Maryland.

### **Commission Members**

Under Chapter 702 (1999), the Commission consists of thirteen members appointed by the Governor with advice and consent of the Senate. The Governor appointed the members on October 1. Of the thirteen members, seven may not have any connection with the management or policy of a health care provider or payor. Of the remaining six members, only two shall be physicians and only two shall be payors. For the initial terms, the Governor is required to appoint five members from the former members of the Health Care Access and Cost Commission, five members from the former Health Resources Planning Commission, and two members who are payors and who were not among the former members of HCACC or HRPC. The former chairman of HCACC serves as the chairman of the new Commission. The term of a member is 4 years. A short biography of each Commission member follows:

#### ***COMMISSION MEMBERS***

---

**Donald E. Wilson, M.D., MACP** became Dean of the University of Maryland School of Medicine in September 1991. In May 1999 he was named Vice President for Medical Affairs of the University of Maryland, Baltimore. Dr. Wilson came to the University of Maryland, Baltimore from the State University of New York Health Science Center in Brooklyn, where he was a professor and chairman of the department of medicine, and physician-in-chief at the University Hospital. He completed his undergraduate education at Harvard University and received his medical degree from Tufts University. Dr. Wilson is a member of the prestigious Institute of Medicine of the National Academy of Sciences. He is a Master of the American College of Physicians, an honor bestowed on less than 0.4% of its members. Dr. Wilson is a co-founder of the Association for Academic Minority Physicians, established in 1986.

---

**Lenys M. Alcoreza** is Vice President of Marketing for AMERIGROUP Maryland, Inc. In this role, she oversees all marketing and outreach efforts for the Mid-Atlantic market. Prior to this position, Ms. Alcoreza has held a number of other positions with AMERIGROUP with progressively greater management responsibility. Before joining AMERIGROUP, Ms. Alcoreza served as regional marketing manager for Health Care USA, a Florida-based HMO with over 30,000 Medicaid members. Ms. Alcoreza holds a B.S. in Business Administration from the State University of New York at Buffalo in 1991.

---

**Evelyn T. Beasley** holds a Master's degree in Administrative Science from Johns Hopkins University. She is a retired educator for the Baltimore City Public School system where she was an elementary/middle school principal for 23 years. Included in Ms. Beasley's many civic interest are her memberships in the N.A.A.C.P., GBC Leadership, Associated Black Charities, and West Arlington Improvement Association.

---

**Walter E. Chase, Sr.** has over thirty-eight years of police experience. Although retired as the police chief of Easton, Mr. Chase continues to be involved in a variety of community and fraternal organizations. A sampling of his current participation includes the Talbot County Branch of the N.A.A.C.P., Talbot County Unit of the American Cancer Society, Eastern Shore Police Association, Kiwanis, and Court Appointed Special Advocates.

---

**Ernest B. Crofoot** is a labor executive with the AFL-CIO. He currently serves on the AFSCME-National Committee for Health Cost and Quality and is a board member for United Seniors. He is a former Commissioner for the Health Services Cost Review Commission. Mr. Crofoot is also active with the Bowie Chapter of the American Association of Retired People.

---

**Larry Ginsburg** has been active in labor and community organizing for 25 years and is currently assistant to the President of the District Service Employees International Union 1199E-DC. He received his BA from the American University in Washington, DC and did postgraduate work in economics at the George Mason University. Mr. Ginsburg's grass roots involvement in politics has benefited several political campaigns.

---

**George S. Malouf, M.D.** is a self-employed practitioner of Ophthalmology at the Malouf Eye Center in Hillcrest Heights. Dr. Malouf received his Doctorate in Medicine from the French Faculty of Medicine in Beirut, Lebanon. He completed his residency training at Boston City Hospital. He has served as the Chief of the Division of Ophthalmology at Prince George's County Hospital Center since 1973. Dr. Malouf's many organized medicine affiliations include Med Chi, the Prince George's County Medical Society, the Maryland Society of Eye Physicians and Surgeons, and the Maryland delegation of the American Medical Association. Dr. Malouf is a member of the Board of Directors of Dimensions Health System. He also served as chairman of the Health Resources Planning Commission.

---

**J. Dennis Murray** is President and CEO of Bay Mills Construction Company. A Calvert County resident since 1974, Mr. Murray is involved in numerous professional and civic activities. He has served on the Board of Directors of Calvert Memorial Hospital in numerous capacities. Mr. Murray is the past chairman of the Calvert County Democratic Central Committee. He has served on the Calvert County Affordable Housing Committee, the Calvert County Citizens Advisory Committee, and the Calvert County Solid Waste Task Force.

---

**John A. Picciotto** is the Senior Vice President, General Counsel, and Corporate Secretary for CareFirst Blue Cross Blue Shield of Maryland. He currently directs the Legal Division and has worked for CareFirst in progressively more senior legal capacities since 1975. Mr. Picciotto obtained his J.D. cum laude from the University of Maryland School of Law in 1974 after completing his undergraduate work at Loyola College. He is a member of both the American and Maryland Bar Associations.

---

**Constance Row's** career includes nearly a decade of experience at the federal level in health policy, legislation, and administration, and a second career in hospital and health care system administration, having served for ten years as a CEO in four community/teaching hospitals and

health systems. She is currently a nonprofit association executive, consultant, and university teacher with a special interest in healthy communities, where her leadership skills have moved many volunteer boards and community groups to create new initiatives to meet community needs. Ms. Row is a graduate of Barnard College, Columbia University and has an MPA from the Maxwell School at Syracuse University.

---

**Catherine Smoot-Haselnus, M.D.** is a self-employed practitioner of Ophthalmology at the Chesapeake Eye Center in Salisbury. Dr. Smoot has held several offices on the Wicomico County Medical Society, including president. She has been on the Board of Trustees for the Maryland Society of Eye Physicians and Surgeons since 1997 and on the Board of Directors of MMPAC since 1990. Dr. Smoot represents the Medical and Chirurgical Faculty of Maryland as a delegate and as a member of Med Chi's Legislative Committee and Board of Trustees.

---

**Ruth Spector** holds a Master's degree in Social Work from the University of Pennsylvania School of Social Work. Her professional experience includes serving as President of the Montgomery County Council where she represented more than 600,000 constituents. She presently serves numerous local organizations and is a board member for the Community Ministry of Montgomery County.

---

**Marc E. Zanger** is President and CEO of Beall, Garner, Screen, and Geare Companies. He has been a leader in the employee benefits field since joining BSG&G in 1976 where he formed the Employee Benefits Division of the company. Mr. Zanger is a member of the Employers Council on Flexible Compensation and the International Foundation of Employee Benefit Consultants.

## **Merger Activities to Date**

### **Transition Teams**

The Executive Committee created nine transition teams each having an area of responsibility for a necessary part of the reorganization. Each transition team had two co-chairs: one each from the former HCACC and the former HRPC. Each team also had from three to five additional members that represented both of the former commissions. These transition teams reported back to the Executive Committee with their progress and for approval of their recommendations. The following listing shows the transition teams, their charges, activities, and accomplishments:

- **Physical Space:** This team was charged with planning the new locations of all staff following the merger and also with coordinating the overall move. The staff of the former HRPC has moved from the 2<sup>nd</sup> floor to the 5<sup>th</sup> floor where the former HCACC was located. The space utilized by the former HRPC staff as well as the existing space of the former HCACC was configured so all members of each of the three projects were consolidated within the project area.
- **Information Systems:** This team was responsible for the integration of the information systems maintained by the two former Commissions. The merger of the network infrastructures, including the servers, workstations, and wiring, has been successfully completed. The separate e-mail systems of the two former Commissions have been integrated, a consolidated website has been created for the new

Commission ([www.mhcc.state.md.us](http://www.mhcc.state.md.us)), mailing lists have been merged, and administrative systems (i.e., word processing; spreadsheet software) have been standardized. In general, all computer tools, files, and databases needed for staff to accomplish their tasks are currently available.

- **State Health Plan Transfer/Local Health Planning:** House Bill 995 requires the Commission to transfer to the Department of Health and Mental Hygiene health planning functions and necessary staff resources for licensed entities in the State health plan that are not required to obtain a certificate of need or an exemption from the certificate of need program. Uncodified provisions also require the Commission to report on the priorities, approximate time frames, and the process for examining major policy issues related to State and local health planning. To satisfy these requirements, this transition team produced a report that provides a logical framework and supporting rationale for transferring certain portions of the State Health Plan and local planning to the Department (see Part IV of consolidated report).
- **New Commission Support and Training:** This transition team produced a Briefing Book for the new Commissioners. As most of the Commission members are familiar only with the activities of their respective Commissions, and there also are several new members with no Commission experience, the Briefing Book gives them an overview and some background on all of the functions for which the new Commission has responsibility. The Briefing Book was distributed at the November Commission meeting. Several briefings are planned for the December, January, and February including sessions on Certificate of Need, Small Group Market Reform, and the HMO Quality and Performance Reports.
- **Budget/Operations:** This transition team was responsible for the initial preparation of the Fiscal Year 2001 budget submission. It also coordinated activities related to procurement, and the user fee assessment. The FY2001 budget has been completed. The user fee assessment is in progress with a new database being implemented due to statutory changes under House Bill 995 that shifts the authority for the assessment from the Maryland Insurance Administration to the Commission.
- **Strategic Planning:** This transition team was responsible for the initial preparation of various studies required under House Bill 995. The team identified seven reports: (1) the Commission's plans for altering its permanent taskforce (final report 1/1/2000); (2) the feasibility, desirability and most efficient method of merging the Health Services Cost Review Commission (HSCRC) into the MHCC (preliminary report: 1/1/2000 and final report: 7/1/2000); (3,4,5) major policy issues to be examined during 2000 and 2001 including the CON process, hospital rate regulation, and state and local health planning (preliminary report: 1/1/2000 and final report: 7/1/2000); (6) a progress report on the merger of the former HCACC and HRPC (preliminary report: 1/1/2000 and final report: 7/1/2000); and (7) a study of the user fee allocation and appropriate funding level for the Commission (final report: 9/1/2000). The transition team created work plans to guide the creation of these reports or, in the cases where the transition team needed additional expertise, assigned the creation of the work plan to the appropriate staff. All of the required reports except the user fee

allocation report and the report on permanent workforce alterations are included in one consolidated report (see Parts II – VI of consolidated report).

- **House Bill 994 Implementation:** This team is responsible for coordinating regulations and other activities associated with the implementation of House Bill 994 of 1999 (Hospital Capacity and Cost Containment Act). The team identified four component issue areas within the bill: (1) increases and decreases in health care facility bed capacity, including new rules for licensed hospital capacity; (2) relocation of existing health care facilities; (3) procedural rules for the conversion to “limited services hospitals”; and (4) changes rules/procedures for the complete or partial closure of hospitals. A preliminary draft of the regulations will be circulated to interested parties in December with Commission approval being sought for the proposed regulations at the January meeting.
- **Communications:** This transition team provided regular updates on transition activities, primarily focused on internal communication. All other transition teams were asked to provide the Communication Team with weekly status reports. The team then produced a “Transition Newsletter” which was published at the end of July, August, and September.
- **Legal:** This transition team is charged with the coordination of all on-going legal issues relevant to both Commissions. The team has drafted a memo addressing regulations to be promulgated, a summary of continuing Commission litigation, and other legal issues affecting the Commission.

## Conclusions

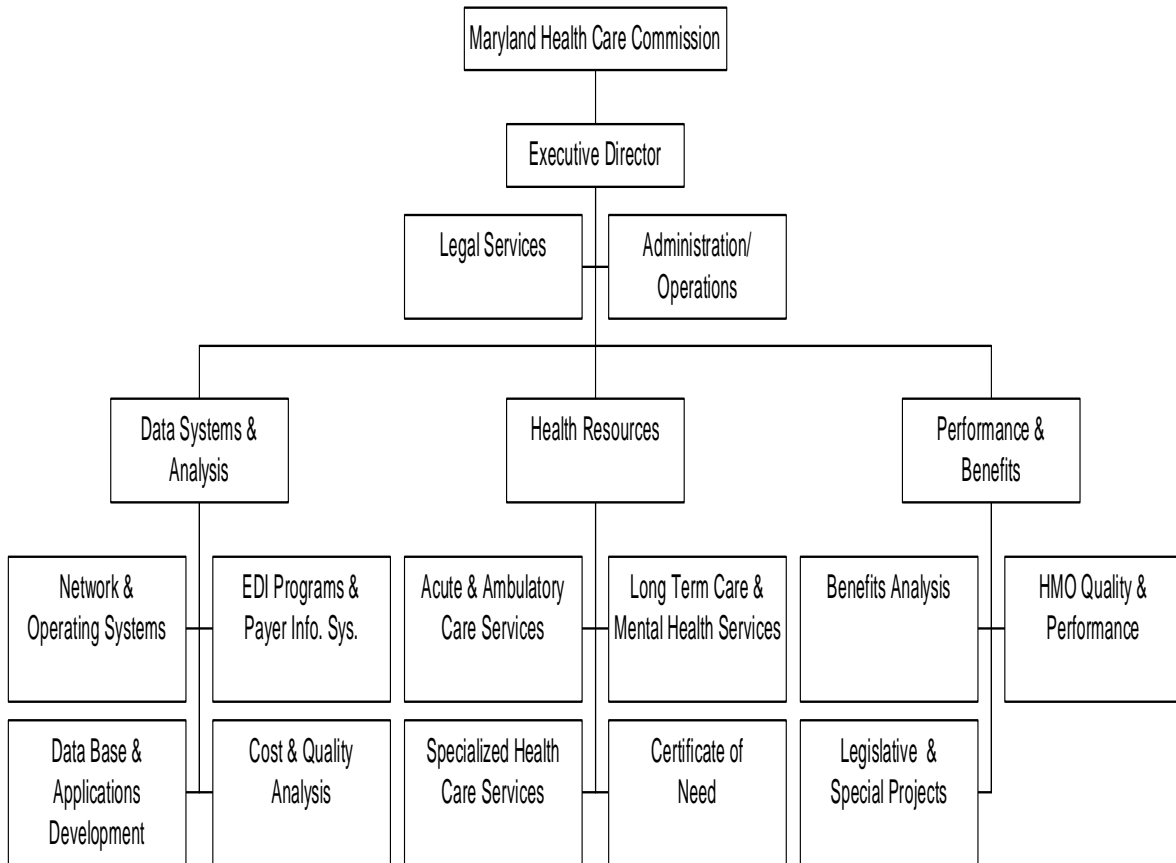
The structural aspects of the merger between the former HCACC and the HRPC have been accomplished. Issues associated with physical relocation, systems integration, personnel, and the budget have been completed in a timely fashion. Although change is never easy and the people who must undergo these changes at times feel uncomfortable or unsettled, the staff of both Commissions undertook the tasks needed to accomplish the merger with a spirit of cooperation and collaboration. The transition teams included staff from both Commissions and they worked well together to achieve the desired results.

While structural issues, by necessity, had to be undertaken in the early stages of the reorganization, a number of functional issues still remain. The new Commission undertook the functional issue related to state and local health planning, but several other policy issues must be approached in the upcoming year. A number of remaining policy issues are identified and delineated through a number of reports required by House Bill 995 including those issues associated with the certificate of need process, hospital rate regulation, and small group market reform. These issues will be assessed using the criteria of improving access to, increasing the quality of, or lowering the costs of health care in Maryland.

We are confident that the merger of the HCACC and the HRPC will contribute to a streamlined health care regulatory system in Maryland and will aid in the articulation, coordination, and implementation of a single state health policy.

ATTACHMENT

**Maryland Health Care Commission**



## **PART II**

### **Work Plan for Examining the Certificate of Need Process**

#### **Preliminary Report**

## **WORK PLAN FOR EXAMINING THE CERTIFICATE OF NEED PROCESS**

Section 11(d)(1) of House Bill 995 (1999) requires the Maryland Health Care Commission (MHCC) to develop priorities, a work plan, and a process for reviewing major policy issues related to the certificate of need (CON) process during calendar years 2000 and 2001. This report addresses which CON-related services have been prioritized for examination during each calendar year and a template defining the examination process/report outline for each group of services. In addition, a general study of the approval process for granting certificate of need should be considered.

### **I. Introduction**

To begin the study of the CON process, the genesis and purpose of the CON program will be examined with particular attention to assessing the future Maryland health care environment and the role of public oversight. There are two possible methods for examining the CON program: (a) by looking at specific services or facilities for which a CON is required to determine if changes are needed; and (b) by examining the procedural rules used by the CON program using a systemic approach. It may be logical to use parallel tracks to separately pursue these two methods for examining the CON program so clear goals can be maintained for each method.

### **II. Issue Priorities and Time Frames: Specific and Systemic**

*Specific Services/Facilities:* Due to the major differences between acute care/hospital related services and long term care services, and the complexity of the issues in each of these major categories, they will be addressed separately.

- *Acute and Ambulatory Care Services:*
  - Specialized hospital services (including cardiac surgery, NICU, organ transplant, and rehabilitation services)
  - General hospital services
  - Ambulatory surgery services
  
- *Long Term Care, Mental Health, and Other Services:*
  - Home health
  - Hospice
  - Comprehensive care
  - Residential treatment centers
  - Mental health and substance abuse services
  - Other services

Within the acute and hospital related services component of the study, priority will be given to studying specialized hospital services and obstetrical services in calendar year 2000. Other general hospital services and ambulatory surgery services will be targeted for study during 2001. In the second component, comprehensive care, home health, and

hospice services will be studied during calendar year 2000. During the following year, residential treatment centers, mental health, substance abuse, and other services regulated by the CON program will be reviewed.

***CON Process Procedural Rules:*** There are various interested organizations who believe that the entire process of gaining a CON approval or an exemption from the CON, should be examined. As such, an examination of the procedural rules that govern the CON process in general should be addressed in addition to the examination of the CON program for a specific service/facility. This section would include several paragraphs describing the CON review process, in general, and a timeline for how this examination would go forward.

### **III. Process Utilized to Examine Priority Issues**

***Specific Services/Facilities:*** This section lays out the general template that both defines the topics to be covered in each study and outlines the contents of the reports that would result.

- *Purposes of a specific CON Program in Maryland*

Describe the law; the State Health Plan review criteria and standards; scope of regulations pertaining to that specific service/facility; history of major regulatory changes.

Discuss perceived strengths and weaknesses of current CON program for that specific service/facility.

- *Examination of Policy Issues* (uses results of previous examinations as well as the current examination process)

Effectiveness of existing CON program for a specific service/facility– Has it accomplished its intended goal? What has been the result? How have its purpose and the relevant aspects of the marketplace changed since the law was instituted?

Alternatives to existing CON program for a specific service/facility - Examine possibilities in re-regulation; deregulation; evidence of free market competition and control; and oversight via licensing. Cite other states' experiences where relevant.

Relationship of CON program for a specific service/facility to other regulatory efforts – such as regulatory oversight by the Office of Health Care Quality, hospital rate regulation, and the assurance of quality.

- *Conclusions and Policy Recommendations*

**CON Process Procedural Rules:** This section lays out the general template that both defines the topics to be covered and outlines the contents of the report that would result. The general format of the study of the CON process procedural rules would be similar to that framework used for the examination of a specific service/facility.

- *Purposes of the CON Process in Maryland*

Describe the law; scope of regulations pertaining to the CON process in general; history of major regulatory changes

Discuss perceived strengths and weaknesses of current CON program in general.

- *Examination of Policy Issues* (uses results of previous examinations as well as the current examination process)

Effectiveness of existing CON process in general – Has it accomplished its intended goal? What has been the result? How have its purpose and the relevant aspects of the marketplace changed since the law was instituted?

Alternatives to existing CON process in general - Examine possibilities in re-regulation; deregulation; evidence of free market competition and control; and oversight via licensing. Cite other states' experiences where relevant.

Relationship of CON process in general to other regulatory efforts – such as regulatory oversight by the Office of Health Care Quality, hospital rate regulation, and the assurance of quality.

- *Conclusions and Policy Recommendations*

**The Role of Technical Advisory Committees:** For each of the tasks outlined above, it is anticipated that the Commission will form a technical advisory committee of interested organizations to aid in its examination of issues related to the CON process regarding specific services and facilities. The membership of the committee would differ for each examination of the CON program for a specific service/facility. In addition, a committee with broader representation would be desirable for the examination of the overall CON program and procedural rules. Staff support will be provided by the MHCC. Technical advisory committee reports will be made available for public comment through either a public hearing or over the Commission's website depending on the subject of the study and the number of organizations affected. All reports will be approved by the Commission prior to submission to the General Assembly.

### **PART III**

#### **Work Plan for Examining Changes in Hospital Rate Regulation**

##### **Preliminary Report**

## **Work Plan for Examining Changes in Hospital Rate Regulation**

Section 11(d)(2) of House Bill 995 (1999) requires the Maryland Health Care Commission (MHCC) and the Health Services Cost Review Commission (HSCRC) to develop priorities, a work plan, and a process for reviewing major policy issues related to hospital rate regulation. Although the legislation contemplates the examination of these issues during calendar years 2000 and 2001, an effort to redesign the rate-setting system is already underway.

### **I. Introduction**

In recent years, hospitals have complained about the growing complexity of the rate-setting system, the diminishing predictability of the system, and what they perceive as the overly restrictive nature of the system. At the same time, the HSCRC has been concerned about deteriorating performance of Maryland hospitals in controlling cost. This deteriorating performance is reflected in both the HSCRC's own measures and recent performance on the Medicare waiver. The HSCRC specifically is frustrated with regulating one unit of service (unit prices) and measuring performance based on a different unit of service (cost and charge per case). When most hospitals agreed to enter into temporary limitations on charge per case which would be in effect from April 1, 1999 to June 30, 2000, the HSCRC committed to spending this period studying and redesigning the rate-setting system.

### **II. Issue Priorities**

The first step in the redesign effort was to better identify the priorities in a review of hospital rate regulation. To do so, the HSCRC contracted with an impartial consultant, the Alpha Center in Washington, to conduct a series of focus groups with various stakeholders in the hospital rate system. Four separate focus groups were convened: third party payers; hospital chief financial officers (CFOs); hospital chief executive officers (CEOs); and hospital board members. The hospital board members were convened in an attempt to receive input from the business community with some familiarity with the rate-setting system. The Alpha Center briefed the HSCRC and the Association of Maryland Hospitals and Health systems (MHA) on the findings of each focus group and submitted a written report of each focus group to the HSCRC.

The hospital board group was disappointing because only 3 people participated. This group opposed hospital rate regulation on principle. Hospital CEOs were the next most hostile group toward regulation. They believed the system is overly complex and "political" in that the rate system benefits certain favored institutions. Hospital CFOs also identified complexity as a problem, but this group appeared to understand that some complexity was a result of attempts to refine the system and make it fairer. Third party payers expressed strong dissatisfaction with the system, but expressed support for financing uncompensated care and graduate medical education in some manner.

The HSCRC's priorities as it approaches the question of redesign are:

- Maintain or improve access to hospital care
- Preserve the Medicare waiver
- Create measurable and enforceable objectives
- Provide strong and clear incentives for all parties
- Promote competition and quality
- Simplify the rate-setting system

### **III. Process Utilized to Examine Priority Issues**

The second step in redesign was to convene a task force to consider the input of these focus groups and to develop recommendations for a redesign of the system. The HSCRC convened a "Redesign Task Force" with representatives from hospitals, payers, business, labor, and the HSCRC. The Task Force was fortunate to have a number of technical consultants, including Dr. Bruce Vladeck, Dr. Stuart Altman, and John Colmers. Dr. Vladeck was formerly the administrator of the Health Care Financing Administration, the federal agency responsible for running the Medicare and Medicaid programs. In addition, Dr. Vladeck worked directly with both the New Jersey and New York hospital rate-setting systems. Dr. Stuart Altman of Brandeis University is the former chairman of the Prospective Payment Assessment Commission, the federal agency that advises Congress on Medicare payments to hospitals. John Colmers was the former executive director of the HSCRC and is current executive director of the MHCC.

The Task Force has been meeting twice a month from September through December. In addition, the task force formed three subcommittees that have been meeting periodically between Task Force meetings. The Measurement Subcommittee is dedicated to considering the appropriate parameters by which the rate-setting system and hospitals should be evaluated in the future, including reviewing the available data sources to employ in performance measurement. The Outpatient Subcommittee is reviewing alternatives to the current methodology for regulating hospital-based outpatient services. The Administrative Subcommittee is exploring ways to increase payer and hospital cooperation to reduce the administrative costs of claims and utilization review. As the subcommittees go about their work, the full Task Force has dedicated most of its time to reviewing alternative methods for regulating inpatient hospital services. The options under review include: a) a revised version of the current unit rate system; b) a per case payment system analogous to the Medicare Prospective Payment System; c) a targeted charge per case system similar to the current agreements in place; and d) a global budget for individual hospitals.

In evaluating different payment systems, the Task Force used the following criteria:

- Cost control
- Access
- Payor and Patient Equity
- Incentives
- Predictability and Stability
- Administrative Feasibility
- Statutory and waiver considerations

#### **IV. Time Frame Required**

The subcommittees are responsible for making recommendations to the full Task Force. The Task Force has been instructed to try to reach consensus in principle by January 1, 2000. Although very aggressive, this timetable would allow review and approval by the HSCRC and sufficient time to resolve technical implementation issues by June 30, 2000. This timetable also would allow the HSCRC to inform the General Assembly of the general direction of redesign and to introduce legislation implementing redesign, if necessary.

The HSCRC will review the recommendations of the Task Force at its January 2000 meeting. The findings of the Task Force and the HSCRC's response to these recommendations will also be reported to the General Assembly in January 2000. If legislation is necessary to implement any of the recommendations, HSCRC staff will meet with the appropriate Committee chairmen to discuss the appropriate manner in which to have legislation drafted and introduced. (January will be too late to have departmental legislation introduced for the 2000 session). The period between January and June 2000 will be dedicated to resolving technical issues related to redesign and implementing the new system. Additional technical groups will be convened during that period, as necessary.

## **PART IV**

### **Report on State Health Plan Transfer And Local Health Planning**

#### **Final Report**

# REPORT ON STATE HEALTH PLAN TRANSFER AND LOCAL HEALTH PLANNING

## INTRODUCTION

### *Scope of the Report*

During the 1999 session, the Maryland General Assembly passed House Bill 995, entitled *Health Care Regulatory Reform – Commission Consolidation (Chapter 702 Annotated Code of Maryland)*. The regulatory responsibilities and duties of the Maryland Health Care Access and Cost Commission and the Maryland Health Resources Planning Commission were integrated, consolidated, and streamlined under the Maryland Health Care Commission (MHCC). Health-General Section 19-121(i) and uncodified language in Section 4 of the bill, as enacted, require the Maryland Health Care Commission to:

. . . transfer to the Department of Health and Mental Hygiene health planning functions and necessary staff resources for licensed entities in the State health plan that are not required to obtain a certificate of need or an exemption from the certificate of need program.

On or before January 1, 2000, the Maryland Health Care Commission shall report, in accordance with § 2-1246 of the State Government Article, to the Senate Finance Committee, the Senate Budget and Taxation Committee, the House Environmental Matters Committee, and the House Appropriations Committee regarding the Commission's plans for altering its permanent workforce.

House Bill 995 also transfers to the Secretary of Health and Mental Hygiene the requirement to provide for a study of systems capacity in health services, previously a responsibility of the Health Resources Planning Commission (HRPC). In § 19-116, the bill calls for the study to:

. . . determine for all health delivery facilities and settings where capacity should be increased or decreased to better meet the needs of the population, . . .

This report fulfills the requirement to identify the health planning functions and necessary staff resources for transfer to the Department of Health and Mental Hygiene (DHMH). It contains an overview of the current health planning functions and *State Health Plan*, a discussion of the major issues related to State and local health planning, and recommendations.

## **OVERVIEW**

### ***Mandated Health Planning Functions of the Maryland Health Care Commission***

Under Health-General § 19-121 of the current law, the MHCC shall adopt a State health plan at least every 5 years. The *State Health Plan* serves two purposes:

1. It establishes health care policy to guide the actions of all State agencies and departments directly or indirectly involved with or responsible for any aspect of regulating, funding, or planning for the health care industry or persons involved in it. Such health-related activities must, by law, be consistent with the plan, to the extent that the budgets of the agencies permit.
2. It is the legal foundation for the Commission's decisions in its regulatory programs. These programs ensure that appropriate changes in the capacity of regulated services and facilities are encouraged and major expenditures for health care facilities are needed. The plan therefore contains the methodologies, standards, and criteria for certificate of need review.

Additional planning functions specified in Section 19-121(e) give the Commission the legal authority to develop standards and policies consistent with the State health plan that relate to the certificate of need (CON) program. The standards shall address the availability, accessibility, cost, and quality of health care. The law requires the Commission to adopt specifications for the development of local health plans and their coordination with the State health plan. Finally, § 19-115 requires the Commission to periodically participate in or do analyses and studies that relate to:

- Adequacy of services and financial resources to meet the needs of the population;
- Distribution of health care resources;
- Allocation of manpower resources;
- Allocation of health care resources;
- Costs of health care in relationship to available financial resources;
- and
- Any other appropriate matter.

## ***The State Health Plan for Maryland***

Section 19-121 of the Health-General Article requires the State health plan. The State health plan must include:

- A description of the components that should comprise the health care system;
- The goals and policies for Maryland's health care system;
- Identification of unmet needs, excess services, minimum access criteria, and services to be regionalized;
- An assessment of the financial resources required and available for the health care system;
- The methodologies, standards, and criteria for certificate of need review; and
- Priority for conversion of acute capacity to alternative uses where appropriate.

The *State Health Plan for Maryland* is comprised of chapters. In general, the chapters include introductory discussion about the *Plan*; overall goals; issues and general policies; program policies and standards; methodologies for projecting need; and definitions of terms. HRPC adopted each chapter as a part of the Code of Maryland Regulations (COMAR); the documents are incorporated by reference into COMAR.

A person is required to have a certification of public need issued by the Commission before developing, operating, or participating in any health care projects for which a CON is required. CON applications are evaluated according to all relevant standards, policies, and criteria in the *State Health Plan*, as well as other criteria for review in the Commission's regulations governing CON determinations. The table below lists the services covered by CON and their corresponding chapters in the *State Health Plan*.

## ***Conclusions***

Review of the *State Health Plan* reveals that state health plan development has been focused primarily on those services that require a CON for initiation or expansion. The broader function of system wide planning is less well developed. In the next section of the report various roles the Department plays in system wide planning for public health purposes will be outlined. The pending transfer of non-CON related functions to the Department presents the opportunity to clarify the distinction between broader system wide planning and planning related to the CON program.

## Services Covered by Certificate of Need and Services Included in the State Health Plan

CON Coverage	SHP Chapter
Medicine, surgery, gynecology, addictions Obstetrics Pediatrics	Acute Inpatient Services (COMAR 10.24.10) Medical, surgical, gynecological, addictions Obstetrical Pediatric
Psychiatry	Psychiatric Services (COMAR 10.24.07)
Rehabilitation	Acute Inpatient Rehabilitation Services (COMAR 10.24.09)
Chronic care Comprehensive care Extended care Home health program Hospice program	Long Term Care Services (COMAR 10.24.08) Special hospitals – chronic Comprehensive care facilities (CCF) Extended care facilities Short stay hospital-based skilled nursing facilities Home health agencies Hospice care programs Adult day care Continuing care retirement communities (CCRC)* Assisted housing, including domiciliary care
Intermediate care	Alcoholism and Drug Abuse Treatment Services (COMAR 10.24.14) Intermediate care facilities for alcohol and drug abuse rehabilitation and subacute detoxification
Residential treatment	Psychiatric Services (COMAR 10.24.07)
Open heart surgery	Specialized Health Care Services - Cardiac Surgery and Therapeutic Catheterization Services (COMAR 10.24.17)
Organ transplant surgery	Specialized Health Care Services - Organ Transplant Services (COMAR 10.24.15)
Burn intensive health care	
Neonatal intensive health care	Specialized Health Care Services – Neonatal Intensive Care Services (COMAR 10.24.18)
Ambulatory surgical center or facility	Ambulatory Surgical Services (COMAR 10.24.11)
Ambulatory care facility	
	Overview (COMAR 10.24.07)
	Emergency Medical Services (COMAR 10.24.07)
	Worcester County (COMAR 10.24.16)

\*Certain CCF beds in CCRCs are exempt from CON review.

## **MAJOR ISSUES RELATED TO STATE AND LOCAL HEALTH PLANNING**

### ***Overlapping Responsibilities for Planning at the State Level***

Responsibility for global planning functions is not clearly defined in current law. Both the Commission and the Secretary of Health and Mental Hygiene are responsible for determining system capacity. The Commission identified unmet needs and excess services in the *State Health Plan* primarily for those services regulated by CON. The Secretary is required by law to comment on the Plan. Both also address system wide levels of manpower resources and population based planning.

The Secretary, per HB 995, is responsible for a separate study of systems capacity that was previously the responsibility of HRPC (§ 19-116). However, there is no definition of its relationship to the State health plan, specification of its timing, or requirement for any ongoing review of its findings. In addition to the study of systems capacity, §2-108 states that the Secretary may do a survey to identify any area in Maryland that has a substantial deficiency in general medical or health care facilities or services.

In addition, there are a number of divisions within DHMH that issue documents about capacity issues within the health care delivery system. The Community and Public Health Administration (CPHA) of the Department of Health and Mental Hygiene is the focal point for the core public health function of assessing population health status and system adequacy. The Office of Health Policy, Office of Public Health Assessment, and Office of Primary Care Services, which are under the direction of CPHA, have responsibilities related to that function.

The Office of Health Policy administers the Core Public Health Funding Program, which provides funding for basic local health services in each of the 24 jurisdictions; coordinates the Local Health Planning Advisory Committee, which provides a forum for addressing issues related to health planning at the local level; and compiles, publishes, and distributes the *Healthy Maryland* documents, which set and monitor progress toward meeting the State's health objectives. The Office of Public Health Assessment supports the State's efforts to assess health status, set priorities, develop strategies, and evaluate interventions by providing a broad range of health surveillance, epidemiological, analytical, and data management activities. The Office of Primary Care Services (OPCS) works to ensure the availability and accessibility of comprehensive primary health care services to all Marylanders. OPCS administers the Loan Assistance Repayment Program, which awards funds for the repayment of medical school loans to physicians who agree to work in primary care Health Professional Shortage Areas (HPSAs).

Historically, there have already been several transfers of planning functions between HRPC and DHMH. Other functions previously transferred include the responsibility for the designation of federal health professional shortage areas (HPSAs), and the publication and development of *Healthy Maryland 2010*.

Health Professional Shortage Areas (HPSAs) are a federal designation established in 1980 to designate areas that are eligible for various federal and state programs. The

process involves interaction between the U.S. Department of Health and Human Services (DHHS), the States, and individual applicants.

In Maryland, the Governor designated the Health Resources Planning Commission as the State health agency to review requests for HPSA designation and offer recommendations to the Governor and, in turn, the federal Department of Health and Human Services. In 1996, the Commission shared its responsibility with the Office of Primary Care Services (OPCS) in the Department of Health and Mental Hygiene. OPCS, which recommends designations of medically underserved populations and areas, took the lead in developing recommendations for areas of the state not previously designated as HPSAs. HRPC retained the responsibility for providing any information, comments, or recommendations related to the continuation of HPSA designations.

In 1998, HRPC transferred the responsibility for the review of HPSA re-designations to the Office of Primary Care Services. HRPC continued to collect data on physician practices in conjunction with the process and cycle for renewing medical licenses. The data set is known as the Maryland Physician Practice Information Data File, and the data are needed to support the development and review of HPSA proposals. MHCC continues to collect this information.

In late 1990, the Health Resources Planning Commission initiated Maryland's response to the U.S. Public Health Service's challenge for "Healthy People 2000," which presented a national strategy for assessing and improving the health of all Americans during a 10-year period. Early in 1991, the Secretary of Health and Mental Hygiene designated HRPC as the lead agency for the analysis and publication of data needed to measure progress toward the health objectives. In 1993, HRPC and the Department of Health and Mental Hygiene (DHMH) jointly released *Healthy Maryland 2000, Volume 1*.

In 1996, DHMH took the lead in releasing *Healthy Maryland 2000, Volume 2*, second in a planned series of publications outlining the health status of Marylanders in relation to the national health objectives. In 1998, DHMH took the responsibility for Healthy Maryland Project 2010, including the development of health improvement plans at the State and local levels.

## ***Conclusions***

Requirements of current law to transfer non-CON related health planning functions to DHMH provide an opportunity to consolidate the state's responsibilities for analyzing present and future manpower requirements for health professionals. In 1988, the General Assembly required the Secretary of Health and Mental Hygiene to report annually to the General Assembly, the Governor, and the Maryland Higher Education Commission (MHEC) on shortages of health occupations and projected statewide employment vacancy rates in hospitals and related institutions. In 1993, the legislature established the Health Manpower Shortage Incentive Grant Program and directed the Secretary to certify annually to the Maryland Higher Education Commission those health occupations in short supply. The determination of shortages guides the allocation of State funds under the program. In the future, the Commission will request that the Secretary assign responsibility for providing certification to MHEC to the appropriate unit in DHMH.

### ***Integration of Health Planning Functions at the Local Level***

Adopted by HRPC in 1990, the current regulations of the Commission specify the organization, funding, and activities of local health planning agencies, which are eligible to enter into a contractual agreement with the Commission. As part of its funding agreement with the local planning agencies, the Commission requires the submission of a local health plan. Section 19-118(d) of the law requires a local health planning agency to be able to develop a local health plan by assessing local health needs and resources, establishing local standards and criteria for service characteristics, consistent with State specifications, and setting local goals and objectives for systems development. The regulations specify that the local health plan is a statement of regional or jurisdictional health care needs and priorities prepared annually, with an assessment of local resources needed to address unmet needs. In fiscal year 1999, 23 of the 24 local health departments signed an annual funding agreement with HRPC to perform local health planning functions. HRPC provided a total of \$375,000 to the local health planning agencies, including \$100,000 in supplemental funds for nine agencies to further their planning activities.

In addition, the Department of Health and Mental Hygiene requires local health departments to submit a comprehensive local health plan. The Core Public Health Funding Program in the Community and Public Health Administration (CPHA) of the Department includes stipulations for the plan, which focuses on community health improvement and public health services. Each local health plan is required to include: (1) an Overview describing and summarizing data on the specific demographic and socioeconomic characteristics of the jurisdiction and any significant trends that have a public health impact; (2) a Needs Assessment describing the methodology for assessing needs and the findings; (3) the Local Public Health Priorities; (4) program plans providing detailed information about how the local health department will use its resources to meet needs in each of the nine core public health service areas; and (5) documentation for the allocation of resources and responsibility within the local health department for carrying out the program plans. The local health plans submitted to CPHA may not provide an complete picture of all local health department programs, or all local health planning. The plan that each local health department submits to CPHA accompanies a request for Core Public Health Funding, which may represent a small portion of the jurisdiction's total budget. Additionally, not all local health departments participate in the Local Health Planning Advisory Committee coordinated by CPHA. In March 1999, the Task Group on Specifications for Local Health Plans, appointed by HRPC, recommended that the two agencies coordinate their requirements.

## **CONCLUSION AND RECOMMENDATIONS**

In 1999, the Maryland General Assembly required the establishment of a streamlined health care regulatory system to better articulate, coordinate, and implement a single State health policy to better serve the residents of this state. The Commission's staff considered a range of options, from keeping the *State Health Plan* intact and transferring the entire *Plan* to the Department of Health and Mental Hygiene, to organizing the transfer and renaming of the *State Health Plan* based on its policy and regulatory purposes. The staff has recommended options it believes will enhance the strengths of the current regulatory system.

The guiding principle in decision-making was the retention of CON- related planning functions by the Maryland Health Care Commission and the transfer of public health-related planning functions to the Department of Health and Mental Hygiene. The staff recommends that state health planning functions that are transferred to DHMH be continued. However, the Department should have discretion with respect to how to implement these functions and coordinate them with local planning activities. It is anticipated that coordination between DHMH and MHCC with regard to sharing information on population demographics, need, and facility capacity, will continue.

### ***Proposed Administrative Changes***

#### **Recommendation 1. Transfer the planning for adult day care centers to the Department of Health and Mental Hygiene.**

Adult day care centers are not covered by the CON program. The Department of Health and Mental Hygiene is responsible for licensing adult day care centers.

#### **Recommendation 2. Transfer the planning for assisted housing, including domiciliary care, to the Department of Health and Mental Hygiene.**

Assisted living programs are not covered by the CON program. The Department of Health and Mental Hygiene issues licenses to providers to operate as assisted living programs. Its new Assisted Living Regulations repealed the regulations and programs previously certified by the Department of Human Resources, the Maryland Department of Aging, and the residential care homes for adults previously licensed or registered by the Department as domiciliary care homes.

#### **Recommendation 3. Transfer the planning for primary care services to the Department of Health and Mental Hygiene.**

The Department of Health and Mental Hygiene has resources committed to identifying populations and areas in need of primary health care services (Health Professional Shortage Areas and Medically Underserved Areas), describing programs or centers that provide primary care services, and recommending ways to improve access.

**Recommendation 4. Transfer the planning for pre-hospital emergency medical services to the Maryland Institute for Emergency Medical Services Systems.**

The Maryland Institute for Emergency Medical Services Systems (MIEMSS) issues licenses for commercial ambulance vehicles and services. MIEMSS is the lead agency for coordinating emergency medical services in the state. The MIEMSS has developed an EMS plan to ensure effective coordination and evaluation of emergency medical services in Maryland.

**Recommendation 5. Transfer to the Department of Health and Mental Hygiene the state health plan functions related to the following: (a) a description of the components that should comprise the health care system; (b) the goals and policies for Maryland's health care system; (c) the identification of unmet needs and excess services for those facilities and services not regulated by the certificate of need program; and (d) an assessment of the financial resources required and available for the health care system.**

The portion of the State health plan that is transferred to the Department will establish a common agenda for assessing and improving the health of all Marylanders. The development of the *Maryland Health Improvement Plan: 2000-2010*, which the Department will publish as part of the Healthy Maryland Project 2010, provides an opportunity to include information about resource distribution and costs in a *Public Health Plan*. The document will establish the goals and strategies for public health improvement and be of general benefit to the residents of Maryland.

**Recommendation 6. Retain in MHCC regulations only the methodologies, standards, and criteria necessary for CON review.**

The Maryland Health Care Commission should retain as COMAR regulations only those sections of the state health plan relating to CON, namely, the methodologies, standards, and criteria for certificate of need review. The Commission may continue to publish policy documents related to its CON program. The Commission may also publish statistical information about the health care system as special documents. This approach should make development, use, and future amendments of the regulations easier. The Commission should provide technical assistance to DHMH regarding the CON-regulated services and facilities in Maryland's health care system.

**Recommendation 7. Use of the term "state health plan" should be modified to distinguish between the global planning functions of DHMH and the CON related planning in MHCC.**

The activities of the MHCC with respect to CON related planning should be referred to as the "Health Services and Facilities Plan" and the global plan of the DHMH as the "Public Health Plan". Renaming the portion of the State health plan that is transferred to the Department and the one used by the Commission for CON decisions will emphasize the different purposes of each document and more realistically reflect the content of each plan. In making this distinction, it may also be worthwhile to consider the appropriateness of user fee funding for these two types of activities. While user fee

funding may be appropriate to a health services and facilities plan, general funds should be expended on a public health plan where all residents are presumed to be the beneficiaries.

**Recommendation 8. Transfer all requirements related to the organization of a local health planning entity and development of a local health plan to DHMH.**

Local health planning agencies are important vehicles for input into the planning and the CON process. The MHCC already has a procedure established by HRPC for obtaining feedback from local planning agencies on CON applications.

Because the current local health plans are more closely aligned with the public health focus of the Department, the local health planning functions and the staff resources that are attached to those activities should be transferred to DHMH. There should be a concerted effort to not duplicate data collection and to disseminate relevant information both to and from the Commission, the Department, and the local agencies. The Secretary should provide to the Commission population-based data, inventories of State-licensed resources in each jurisdiction, and copies of the state and local *Public Health Plans*. The Commission should provide to the state and local health departments statistical information that the Commission is authorized to collect, including inventories of CON-approved resources. Funding for local planning activities should be negotiated between DHMH and the local entities.

**PART V**

**Work Plan for Examining Issues Related to the  
Comprehensive Standard Health Benefit Plan**

**Preliminary Report**

## **Work Plan for Examining Issues Related to the Comprehensive Standard Health Benefit Plan**

Section 11(d)(4) of House Bill 995 (1999) requires the Maryland Health Care Commission (MHCC) to list its priorities, approximate time frames and process for examining major policy issues. In addition to the topics enumerated in statute, the Commission will examine whether shared oversight of the small group health insurance market with the Maryland Insurance Administration (MIA) is still an appropriate and efficient method of administration. Organizationally, responsibility for the small group market is under the Deputy Director for Performance and Benefits within the Maryland Health Care Commission and under the Associate Commissioner for Life and Health within the Maryland Insurance Administration.

### **I. Introduction and History**

As originally enacted in 1993, responsibility for the administration of the small group market (2-50 employees) was divided between the Health Care Access and Cost Commission (HCACC) (now Maryland Health Care Commission) and the Maryland Insurance Administration. The small group market reforms enacted included guaranteed issuance and renewability, modified community rating (current  $\pm$  40%) and the elimination of preexisting condition limitations. Further, the law required carriers who sell policies to small employers to sell only the Comprehensive Standard Health Benefit Plan (CSHBP). By statute, the CSHBP must include a breadth of benefits that are, at least, the actuarial equivalent of a federally qualified HMO. The average premium rate for the CSHBP, however, may not exceed an affordability cap of 12% of Maryland's average annual wage. Benefits may be enhanced by riders but they must be priced separately.

The HCACC was responsible for the original design of the Comprehensive Standard Health Benefits Plan (CSHBP) in 1993. The Commission convened a workgroup and held public hearings on its benefit design proposal. Regulations to implement the CSHBP were jointly promulgated by the HCACC and the MIA.

Since the small group market reforms became effective on July 1, 1994, HCACC has had responsibility for conducting an annual review of the CSHBP. This includes conducting a financial survey to assure average premiums are under the affordability cap of 12 percent of Maryland's average wage and entertaining changes to the benefit plan from legislative proposals and stakeholders. Any changes made to the CSHBP are jointly promulgated with the MIA. The MHCC will continue these duties (see Attachment – work flow chart).

The MIA's responsibility in the small group market is to assure compliance with the joint regulations in insurance contracts. The MIA must approve contracts, rates and forms, as well as monitor carrier marketing.

Historically, the joint cooperation of the HCACC (now MHCC) and the MIA has worked well. The MHCC, as an independent commission, is able to consider benefit changes impartially, apart from political pressure. The MIA is able to apply its experience in reviewing fully insured contracts in other markets to the small group. Indications of the effectiveness of small group market reforms are as follows:

- The number of covered lives in the small group market has grown 20 percent to almost one-half million persons.
- Average premiums have remained under the 12 percent average annual income affordability cap and are currently at 84 percent of the cap.
- More employee groups are offering coverage (54,000 in 1998 as compared to 44,000 in 1995).
- While the number of carriers in small group has declined from 32 in 1995 to 25 in 1998, this is still a very competitive market. Most of the attrition occurred immediately after the reforms were implemented.
- The choice of delivery systems for small employers (indemnity, PPO, POS, HMO) has increased.
- Regulations making annual changes have been promulgated in a timely way to assure that contracts are in compliance when new regulations take effect.

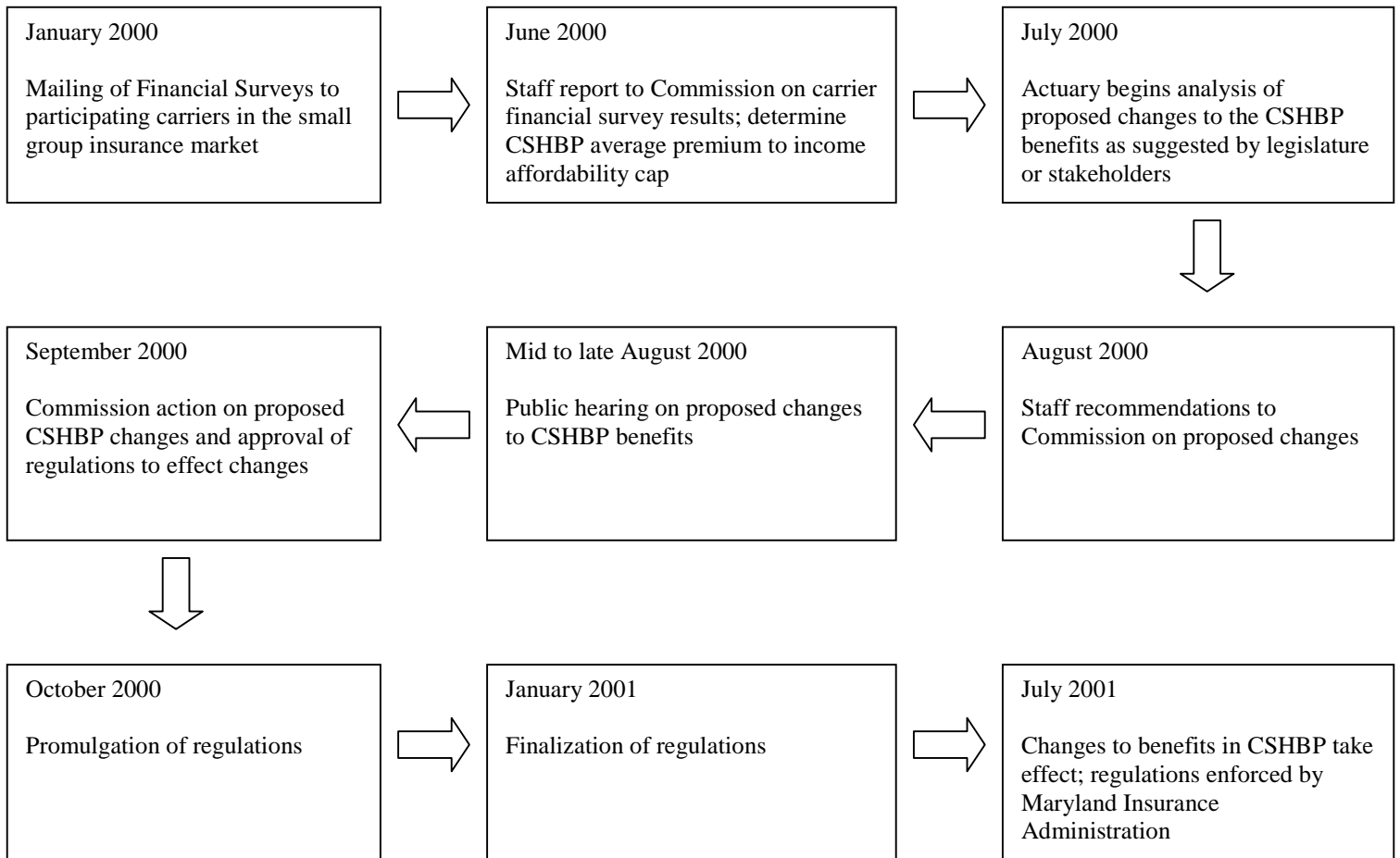
## **II. Issue Priorities, Process, and Time Frame**

While all of the above are indications that the joint administration of the small group market is working well, the MHCC and the MIA believe, that it is important to obtain the input of carriers, brokers, small employers, and consumers about their perception of how the process works. For that reason, the Commission proposes that a joint “white paper” outlining the current functions of both entities be prepared by staff for circulation and that a public hearing be held in late April or early May to determine whether changes in administration are needed. Specifically, the paper will focus on:

- Current linkages/ease of communication
- Regulatory process
- Responsiveness to stakeholder issues
- Duplication of data collection

The Maryland Insurance Commissioner, the Executive Director of the MHCC, and the Commission will review the input from the public hearing. Recommendations for future action will be included in the MHCC’s final report in June.

### Timeline for the Comprehensive Standard Health Benefit Plan (CSHBP)



## **PART VI**

### **Report on the Potential Merger of the Health Services Cost Review Commission and the Maryland Health Care Commission**

#### **Preliminary Report**

## **Report on the Potential Merger of the Health Services Cost Review Commission and the Maryland Health Care Commission**

House Bill 995 (Chapter 702 of the Acts of 1999) requires the Maryland Health Care Commission (MHCC) and the Health Services Cost Review Commission (HSCRC), in consultation with the Maryland Insurance Administration and the Department of Health and Mental Hygiene, to study the “feasibility, desirability, and the most efficient method of reorganizing the duties and responsibilities” of the two commissions. A preliminary report is due January 1, 2000, and a final report containing any specific recommendations for consolidation is due July 1, 2000.

### **I. Introduction**

Under the bill, the Chairmen and the Executive Directors of the MHCC and the HSCRC are responsible for the direct evaluation of feasibility and desirability. Further, they are also asked to determine the best method of reorganizing the duties and responsibilities of the two commissions under one commission. To accomplish this task, the chairs and executive directors are required to meet at least quarterly, beginning October 1, 1999.

The first of these meetings was held November 1, 1999, and it was unanimously agreed that the General Assembly should delay consideration of further consolidation until the 2001 Session. It was acknowledged that the recent merger between the former Health Care Access and Cost Commission (HCACC) and the Health Resources Planning Commission (HRPC) has demanded much effort, and the final outcome of the merger has not yet been learned. Additionally, House Bill 995 commits the MHCC to evaluating the current certificate of need process and the HSCRC to the redesign of the current hospital rate-setting system, two major Maryland health care regulatory policies. It is envisioned that these statutory responsibilities will require the full attention of both Commissions throughout the upcoming 2000 Session and Interim.

The staff of the two commissions have also met regularly to discuss and outline the work plan that will guide both the interim and final reports required under House Bill 995. Any recommendations associated with regulatory consolidation will be developed by the executive committee, and approved by the members of the two commissions.

### **II. Feasibility and Desirability of Further Consolidation**

The first step in examining the feasibility and desirability of further commission consolidation is to identify the areas of overlapping jurisdiction and mutual policy interests of the respective commissions. This would indicate whether duplication exists, making the decision to realign functions and the planning process of consolidation easier.

Under current law, the MHCC oversees the certificate of need process, the state health plan, design of the small group market and the substantial, available, and affordable coverage (SAAC) program benefit packages, development of performance report cards for hospital and ambulatory surgical facilities, and implementation of medical care database system primarily for outpatient encounters. The HSCRC regulates hospital rates, administers the SAAC differential, and maintains hospital financial and discharge databases. Areas of shared interest include hospital capital projects and performance, data coordination, ambulatory surgical facilities, and the SAAC program.

In determining whether to proceed with further consolidation, several key questions must be addressed by the decision-making group, including:

- How much functional duplication currently exists between the MHCC and the HSCRC?
- What are the potential administrative, budgetary, and other efficiencies that could result from consolidation?
- Do the benefits of consolidation outweigh the potential costs of disruption to current activities of the two commissions?
- Can part-time volunteer Commissioners sufficiently oversee the functions and responsibilities of the MHCC and the HSCRC?
- Are there means outside of consolidation that can accomplish the goals of reducing functional duplication, administrative and budgetary savings, and increasing policy coordination? If so, in what areas could policy be better articulated to achieve coordination between the MHCC and the HSCRC?

### **III. Work Plan for Final Report**

Quarterly meetings of the Chairman and the Executive Directors of the two commissions will be devoted to achieving the tasks outlined above. Presentations will be made at each meeting on selected topics by staff so that the Chairmen can better understand opportunities for coordination. Although House Bill 995 requires the two commissions to address the most efficient method for the consolidation of the MHCC and the HSCRC, that portion of the report will be delayed until the July 2000 final report after any decision to merge has been reached. The joint recommendations of the two commission chairs will be presented at a public hearing to obtain input from interested parties. Finally, recommendations will be reviewed and approved by the members of both commissions prior to presentation of the final report to the General Assembly.

If further consolidation is recommended by the commissions, the most likely model to accomplish the merger of the HSCRC and the MHCC would be to utilize the methodology and framework used in the HRPC/HCACC merger. This method would include convening an executive committee to oversee the reorganization along with the

use of transition teams to undertake the detailed structural and functional tasks. The transition teams would report periodically to the executive team. The final report will include any recommendations on further consolidation, and will describe the process used to merge the HCACC and the HRPC, using the lessons learned from the initial merger to apply to any future consolidation. A work plan and timetable for the merger of the MHCC and the HSCRC will also be included in the final report, if necessary.